UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF MICHIGAN
SOUTHERN DIVISION

WILLARD L. SLOAN, EUGENE J. WINNINGHAM, and JAMES L. KELLEY, on behalf of themselves and a similarly situated class,

Plaintiffs,

v.

BORGWARNER, INC., BORGWARNER FLEXIBLE BENEFITS PLANS and BORGWARNER DIVERSIFIED TRANSMISSION PRODUCTS, INC.,

Defendants.
_____/

Case No. 09-cv-10918
Hon. Paul D. Borman
Magistrate Mona K. Majzoub

Class Action

EXHIBIT 20

TO

PLAINTIFFS' MOTION FOR SUMMARY JUDGMENT AS TO LIABILITY

BorgWarner

2009 Benefit Enrollment Form
Muncie Hourly Pre-Medicare Retiree Healthcare Coverage Effective 5/1/09
(For Individuals Not Yet Eligible for Medicare)

▶Unlike previous years, this year you **MUST** complete and submit the enrollment form by **April 1**, or you and members of your household who are not eligible for Medicare will not have healthcare coverage effective May 1, 2009.

Instructions: Complete this form for eligible family members who are NOT eligible for Medicare.

1 GENERAL INFORMATION

Retiree contact information:

In the event we need to contact you about your retiree healthcare coverage, please provide an updated phone number and email address (if available).

Phone: _____

Email: _____

(If available)

2 PLAN ELECTION

Please select one of the following plans for you and your eligible dependents. You cannot select separate plans for each member.

I am electing the following BorgWarner DTP Retiree Healthcare Plan (check one)	☐Option #1 Anthem PPO		☐Option #2 Lumenos Health Reimbursement Acct		☐Option #3 No Coverage
Your Monthly Contribution **Per Member** Will Be:	If the Retiree had 25 or more Years of Service: $58	If the Retiree had Less than 25 Years of Service: $87	If the Retiree had 25 or more Years of Service: $30	If the Retiree had Less than 25 Years of Service: $45	$0

Below is the information we have on file regarding you and your dependents who are not eligible for Medicare. Please review and confirm who will continue to have coverage under the elected plan by selecting the appropriate box below.

Name	Relationship	Last 4 digits Of Social Security #	Date of Birth	Enroll 5/1/09 In BW DTP Plan Selected Above	Remove from BW DTP Plan Selected Above	Monthly Contribution Per Member from Options Above
A.				☐	☐	$
B.				☐	☐	$
C.				☐	☐	$
D.				☐	☐	$
E.				☐	☐	$
				Total Monthly Healthcare Contribution (Add rows A-E)		$

Note: In April, you will receive a premium payment letter from: BorgWarner Muncie Retiree Service Center, 3149 Haggerty Highway, Commerce Twp, MI 48390-1724, 1-866-201-3995.

See Reverse Side

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3 COORDINATING BENEFITS BETWEEN HEALTHCARE PLANS

BorgWarner DTP coordinates benefits with other health insurance plans. If you are eligible to participate in another plan, you are not required to enroll. However, if you decline BorgWarner DTP retiree healthcare coverage for yourself or your dependents, you will not be eligible to enroll in this plan in the future. The company requires spouses and eligible dependents of retirees to enroll in available medical coverage offered through another employer. This plan will pay primary and your BorgWarner DTP coverage will pay secondary for members of your family. If your spouse and other eligible dependents do not enroll in other group coverage available to them, your spouse and/or your dependents will not be eligible for BorgWarner DTP's retiree healthcare benefits.

Please answer the following questions regarding eligibility for other healthcare coverage:

1. Are you covered under another healthcare plan, such as another employer plan, Veteran's plan or Medicare?
   Yes ☐ No ☐

   If yes: Name of Other Plan:_____ Group #:_____

   Address:_____

2. Is your spouse covered under another healthcare plan, such as another employer plan, Veteran's plan or Medicare?
   Yes ☐ No ☐

   If yes: Name of Other Plan:_____ Group #:_____

   Address:_____

3. Are your eligible children covered under another healthcare plan, such as another employer plan, Veteran's plan or Medicare?
   Yes ☐ No ☐

   If yes: Name of Other Plan:_____ Group #:_____

   Address:_____

4 CERTIFICATION AND AUTHORIZATION

- I understand this enrollment form must be mailed by **April 1, 2009,** in order to be eligible for healthcare coverage effective May 1, 2009.
- I understand that the coverage I have elected and the contributions shown will become effective May 1, 2009, and that an individual's coverage will end on the first of the month during which he or she becomes eligible for Medicare.
- I understand that payment for coverage for the month of May is due May 1, 2009 and that if I don't pay by the first of the month, my coverage will be suspended for 30 days; with retroactive reinstatement if payment is received during the 30-day grace period.
- If I have declined coverage, I certify that I no longer wish to participate in BorgWarner DTP Retiree healthcare coverage and will not be eligible to rejoin the plan in the future.
- I understand that adjustments to contributions, deductibles, co-payments and out-of-pocket limits are determined on an annual basis and that BorgWarner DTP has the right to modify, suspend or end the benefits I have elected, in whole or in part, at any time.
- I understand that knowingly providing false information may be grounds for termination of benefits and that any person who knowingly and with intent to defraud submits an application or files a claim containing any materially false or misleading information commits a fraudulent act, which is a crime. The company may seek reimbursement from me in the amount of any and all claims that have been paid on behalf of an ineligible individual.

Signature: **Date:**

Please submit your completed enrollment form to the (Muncie Plant) Insurance Office:

By Mail: BorgWarner DTP
Attn: Insurance Office
5401 W Kilgore Ave
Muncie, IN 47304

By Confidential Fax:
Attn: Insurance Office
(765) 286-6292